FOR BHF USE

LL1

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

2012
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2012)

I. IDPH License ID Number: 0044362

Facility Name: Resurrection Nursing and Rehab Center

Address: 1001 North Greenwood (Number) Park Ridge (City) 60068 (Zip Code)

County: Cook

Telephone Number: (847) 692-5600 **Fax #** (847) 692-2305

HFS ID Number:

Date of Initial License for Current Owners: 05/01/1980

Type of Ownership:

X	VOLUNTARY,NON-PROFIT		PROPRIETARY		GOVERNMENTAL
X	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code 501C(3)			Corporation		Other
			"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Raj Shah **Telephone Number:** (630) 530-7100 Ext 107
Email Address:

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 07/01/2011 to 06/30/2012 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) 10/30/2012 (Date)
(Type or Print Name) Michael Volante
(Title) System Director - Reimbursement

Paid Preparer

(Signed) 10/27/2012 (Date)
(Print Name and Title) Raj Shah, Senior Reimbursement Consultant
(Firm Name & Address) Strategic Reimbursement, Inc., 360 W Butterfield Road, Elmhurst, IL 60126
(Telephone) (630) 530-7100 Ext 107 Fax # (630) 530-7106

MAIL TO: BUREAU OF HEALTH FINANCE
ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

Facility Name & ID Number Resurrection Nursing and Rehab Center # 0044362 Report Period Beginning: 07/01/2011 Ending: 06/30/2012

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds N/A

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	298	Skilled (SNF)	366	109,068	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	298	TOTALS	366	109,068	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	31,211	10,869	20,490	62,570	8
9	SNF/PED					9
10	ICF	20,945	5,525	277	26,747	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	52,156	16,394	20,767	89,317	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 81.89%

D. How many bed-hold days during this year were paid by the Department?
None (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
None

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 03/26/1998

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 03/26/1998 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 298 and days of care provided 62,570

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 06/30/2012 Fiscal Year: 06/30/2012

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number Resurrection Nursing and Rehab Center # 0044362 Report Period Beginning: 07/01/2011 Ending: 06/30/2012

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger Salary/Wage 1	Supplies 2	Other 3	Total 4	Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY 9	10	
	A. General Services											
1	Dietary	659,843	140,329	25,274	825,446		825,446		825,446			1
2	Food Purchase		681,252		681,252		681,252	(6,645)	674,607			2
3	Housekeeping	387,764	48,924	8,182	444,870		444,870		444,870			3
4	Laundry	176,745	81,746	4,937	263,428		263,428	(18,450)	244,978			4
5	Heat and Other Utilities			317,352	317,352		317,352		317,352			5
6	Maintenance	175,063	34,795	167,116	376,974		376,974		376,974			6
7	Other (specify):*											7
8	**TOTAL General Services**	1,399,415	987,046	522,861	2,909,322		2,909,322	(25,095)	2,884,227			8
	B. Health Care and Programs											
9	Medical Director											9
10	Nursing and Medical Records	6,665,533	422,446	278,788	7,366,767		7,366,767	(108,005)	7,258,762			10
10a	Therapy	1,150,707	6,148	67,080	1,223,935		1,223,935		1,223,935			10a
11	Activities	197,216	6,513	4,625	208,354		208,354	(519)	207,835			11
12	Social Services	274,895	7,980	9,303	292,178		292,178		292,178			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	8,288,351	443,087	359,796	9,091,234		9,091,234	(108,524)	8,982,710			16
	C. General Administration											
17	Administrative			2,013,099	2,013,099		2,013,099	117,425	2,130,524			17
18	Directors Fees											18
19	Professional Services											19
20	Dues, Fees, Subscriptions & Promotions			8,573	8,573		8,573	619	9,192			20
21	Clerical & General Office Expenses	1,096,201	56,486	(207,841)	944,846		944,846	221,933	1,166,779			21
22	Employee Benefits & Payroll Taxes			3,107,760	3,107,760		3,107,760		3,107,760			22
23	Inservice Training & Education											23
24	Travel and Seminar											24
25	Other Admin. Staff Transportation			964	964		964		964			25
26	Insurance-Prop.Liab.Malpractice			832,287	832,287		832,287		832,287			26
27	Other (specify):*											27
28	**TOTAL General Administration**	1,096,201	56,486	5,754,842	6,907,529		6,907,529	339,977	7,247,506			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	10,783,967	1,486,619	6,637,499	18,908,085		18,908,085	206,358	19,114,443			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**
NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Resurrection Nursing and Rehab Center #0044362 Report Period Beginning: 07/01/2011 Ending: 06/30/2012

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			867,130	867,130		867,130		867,130			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			227,503	227,503		227,503	(196,963)	30,540			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			28,931	28,931		28,931		28,931			35
36	Other (specify):*											36
37	**TOTAL Ownership**			1,123,564	1,123,564		1,123,564	(196,963)	926,601			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		1,942,692		1,942,692		1,942,692	85,459	2,028,151			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			709,744	709,744		709,744		709,744			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**		1,942,692	709,744	2,652,436		2,652,436	85,459	2,737,895			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	10,783,967	3,429,311	8,470,807	22,684,085		22,684,085	94,854	22,778,939			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number Resurrection Nursing and Rehab Center # 0044362 Report Period Beginning: 07/01/2011 Ending: 06/30/2012

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 BHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(6,645)	2		4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients	(18,450)	4		8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional				25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule				29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (25,095)		$	30

BHF USE ONLY								
48		49		50		51		52

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (25,095)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44						44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

Resurrection Nursing and Rehab Center

ID# 0044362

Report Period Beginning: 07/01/2011

Ending: 06/30/2012

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1		$		1
2	Activities - Negative Non Op Income	100	11	2
3	Beauty/Barber Shop Svc Revenue	(22,546)	10	3
4	Admin - Other Rev	(3,636)	17	4
5	Charity Care credit from Res hosp-recorded as reduction	344,800	21	5
6	Interest Income - limited to int exp	(227,503)	32	6
7	Marketing Exp	(1,806)	21	7
8	investment fees	30,540	32	8
9				9
10	Administrator's Salary	121,061	17	10
11	Administrator's Salary	(121,061)	21	11
12				12
13	Dues and Subscription	619	20	13
14	Dues and Subscription	(619)	11	14
15				15
16	LAB	(70,247)	10	16
17	X-RAY	(15,212)	10	17
18	LAB AND XRAY	85,459	39	18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32

33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	119,949		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Resurrection Nursing and Rehab Center **#** 0044362 **Report Period Beginning:** 07/01/2011 **Ending:** 06/30/2012

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(6,645)	0	0	0	0	0	0	0	0	0	0	(6,645)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	(18,450)	0	0	0	0	0	0	0	0	0	0	(18,450)	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(25,095)	0	0	0	0	0	0	0	0	0	0	(25,095)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	(108,005)	0	0	0	0	0	0	0	0	0	0	(108,005)	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	(519)	0	0	0	0	0	0	0	0	0	0	(519)	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	(108,524)	0	0	0	0	0	0	0	0	0	0	(108,524)	16
	C. General Administration													
17	Administrative	117,425	0	0	0	0	0	0	0	0	0	0	117,425	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	619	0	0	0	0	0	0	0	0	0	0	619	20
21	Clerical & General Office Expenses	221,933	0	0	0	0	0	0	0	0	0	0	221,933	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	339,977	0	0	0	0	0	0	0	0	0	0	339,977	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	206,358	0	0	0	0	0	0	0	0	0	0	206,358	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Resurrection Nursing and Rehab Center **#** 0044362 **Report Period Beginning:** 07/01/2011 **Ending:** 06/30/2012

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense D. Ownership	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
30	Depreciation	0	0	0	0	0	0	0	0	0	0	0	0	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(196,963)	0	0	0	0	0	0	0	0	0	0	(196,963)	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(196,963)	0	0	0	0	0	0	0	0	0	0	(196,963)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	85,459	0	0	0	0	0	0	0	0	0	0	85,459	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	85,459	0	0	0	0	0	0	0	0	0	0	85,459	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	94,854	0	0	0	0	0	0	0	0	0	0	94,854	45

Facility Name & ID Number Resurrection Nursing and Rehab Center # 0044362 Report Period Beginning: 07/01/2011 Ending: 06/30/2012

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Use Page 6-Supplemental as necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Resurrection Health Care	100	See Attached PG6-Supp		See Attached PG6-Supp		

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	17	Adminstrative	$ 2,013,099	Resurrection Health Care	100.00%	$ 2,013,099	$	1
2	V	30	Dereciation	281,274	Resurrection Health Care	100.00%	281,274		2
3	V	32	Interest	227,503	Resurrection Health Care	100.00%	227,503		3
4	V	39	Pharmacy	1,942,692	Resurrection Health Care	100.00%	1,942,692		4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 4,464,568			$ 4,464,568	$ *	14

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

Facility Name & ID Number Resurrection Nursing and Rehab Center # 0044362 Report Period Beginning: 07/01/2011 Ending: 06/30/2012

VII. RELATED PARTIES

A. (Continued) **Enter below the names of ALL owners and related organizations (parties) as defined in the instructions.**

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1	Resurrection Health Care Corp. (RHCC)	100	Resurrection Senior Services	Chicago	Provena-Resurrectio	Chicago	Health Care	1
2					Resurrection Univers	Oak Park	Health Care	2
3					Holy Family Health C	Des Plaines	Health Care	3
4					Holy Family Medical	Des Plaines	Health Care	4
5					Mount Loretto Nursi	Amsterdam	Senior Living	5
6					Our Lady of the Resu	Chicago	Health Care	6
7					Provena Care & Hom	Mokena	Health Care	7
8					Provena Health	Frankfort	Health Care	8
9					Provena Home Healt	Mokena	Health Care	9
10					Provena Hospitals	Frankfort	Health Care	10
11					Provena Laverna Ter	Mokena	Health Care	11
12					Provena Self-Insuran	Frankfort	Insurance	12
13					Provena Senior Servi	Mokena	Health Care	13
14					Proviso Family Srvcs	Broadview	Health Care	14
15					Resurrection Ambula	Chicago	Health Care	15
16					Resurrection Develo	Des Plaines	Fundraising	16
17								17
18					Resurrection Health	Des Plaines	Health Care	18
19					Resurrection Home H	Morton Grove	Home Care	19
20					Resurrection Medica	Chicago	Health Care	20
21					Resurrection Medica	Chicago	Fundraising	21
22					Resurrection Ministr	Castleton	Parent Corp	22
23					Resurrection Nursing	Castleton	Senior Living	23
24								24
25					Resurrection Service	Chicago	Health Care	25
26					Saint Francis Hospita	Evanston	Health Care	26
27					Saint Francis Hospita	Evanston	Fundraising	27
28					Saints Mary and Eliza	Chicago	Health Care	28
29					St. Joseph Hospital	Chicago	Health Care	29
30								30

Facility Name & ID Number Resurrection Nursing and Rehab Center # 0044362 Report Period Beginning: 07/01/2011 Ending: 06/30/2012

VII. RELATED PARTIES

A. (Continued) Enter below the names of ALL owners and related organizations (parties) as defined in the instructions.

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1	John Walton - Thru 10/31/11	BOD						1
2	Sr. Donna Marie Wolowicki thru 9/30/11	BOD						2
3	Nicola Byrne thru 12/16/11	BOD						3
4	Demetrios Kouzios thru 12/1/11	BOD						4
5	Connie March - effective 11/1/11	BOD						5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30

Facility Name & ID Number Resurrection Nursing and Rehab Center # 0044362 Report Period Beginning: 07/01/2011 Ending: 06/30/2012

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	N/A								$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number Resurrection Nursing and Rehab Center # 0044362 Report Period Beginning: 07/01/2011 Ending: 6/30/2012

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Resurrection Health Care
Street Address: 100 North River Road
City / State / Zip Code: Des Plaines, IL 60016
Phone Number: (847) 813-3719
Fax Number: (847) 813-3786

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	17	Adminstrative				$	$		$ 2,013,099	1
2	30	Dereciation							281,274	2
3	32	Interest							227,503	3
4	39	Pharmacy							1,942,692	4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$ 4,464,568	25

Facility Name & ID Number Resurrection Nursing and Rehab Center # 0044362 Report Period Beginning: 07/01/2011 Ending: 06/30/2012

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
	A. Directly Facility Related											
	Long-Term											
1	Allocation from Home Office						$	$			$ 227,503	1
2	Investment Expenses										30,540	2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related						$	$			$ 258,043	9
	B. Non-Facility Related*											
10	Less: Interest Income Offset										(227,503)	10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$ (227,503)	14
15	TOTALS (line 9+line14)						$	$			$ 30,540	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. **$** N/A **Line #** _____

*** Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)**

**** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)**

Facility Name & ID Number Resurrection Nursing and Rehab Center # 0044362 Report Period Beginning: 07/01/2011 Ending: 06/30/2012

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2011 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		$	2
3. Under or (over) accrual (line 2 minus line 1).		$	3
4. Real Estate Tax accrual used for 2012 report. (Detail and explain your calculation of this accrual on the lines below.)		$	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**		$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**		$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2007		8
	2008		9
	2009		10
	2010		11
	2011	N/A	12

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2011	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

2011 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Resurrection Nursing and Rehab Center COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0044362

CONTACT PERSON REGARDING THIS REPORT Michael Gordon, Business Unit CFO

TELEPHONE (708) 478-7911 FAX #: (708) 478-5387

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2011 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2011.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.			$	$
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$	$

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? _____ YES N/A NO

If YES, attach an explanation and a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the original 2011 tax bills which were listed in Section A to this statement. Be sure to use the 2011 tax bill which is normally paid during 2012.

PLEASE NOTE: ***Payment information from the Internet*** or otherwise is ***not considered acceptable tax bill documentation*** . Facilities located in Cook County are required to provide copies of their original **second installment** tax bill.

Facility Name & ID Number Resurrection Nursing and Rehab Center # 0044362 Report Period Beginning: 07/01/2011 Ending: 06/30/2012

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 99,460 B. General Construction Type: Exterior Brick & Block Frame Steel Number of Stories 3+Ground

C. Does the Operating Entity? [X] (a) Own the Facility [ ] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [X] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: N/A
2. Number of Years Over Which it is Being Amortized:
3. Current Period Amortization: N/A
4. Dates Incurred:

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Resident Care	126,500	1983	$ 580,293	1
2					2
3	TOTALS	126,500		$ 580,293	3

Facility Name & ID Number Resurrection Nursing and Rehab Center # 0044362 Report Period Beginning: 07/01/2011 Ending: 06/30/2012

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	298			1982	$ 20,768	$ -	20	$ -	$	$ 20,768	4
5				1983	6,333,842	209,100	15-30	209,100		6,124,701	5
6											6
7											7
8											8
	Improvement Type**										
9	Various			1984	1,736,552	-	5-20	-		1,736,545	9
10	Various			1985	3,892	-	10-10	-		3,892	10
11	Various			1986	64,677	-	10-20	-		64,673	11
12	Various			1987	41,840	422	10-40	422		35,723	12
13	Various			1988	123,462	-	10-20	-		123,460	13
14	Various			1989	238,210	-	10-20	-		238,210	14
15	Various			1990	257,820	-	5-20	-		257,817	15
16	Various			1991	82,524	-	10-20	-		82,518	16
17	Various			1992	96,740	207	10-20	207		96,737	17
18	Various			1993	111,721	3,131	12-20	3,131		109,934	18
19	Various			1994	259,632	3,803	5-20	3,803		253,924	19
20	Various			1995	577,244	5,117	5-17	5,117		576,915	20
21	Various			1996	226,541	4,762	5-20	4,762		220,553	21
22	Various			1997	1,120,058	34,374	5-20	34,374		1,070,433	22
23	Various			1998	80,880	3,719	5-15	3,719		79,020	23
24	Various			1999	2,005	134	15-15	134		1,671	24
25	Various			2000	324,909	21,082	10-15	21,082		272,139	25
26	Various			2001	1,344,769	87,176	5-20	87,176		1,037,160	26
27	Various			2002	75,146	4,659	10-15	4,659		60,820	27
28	Various			2003	283,076	11,136	4-15	11,136		266,581	28
29	Various			2004	11,852	548	5-15	548		11,056	29
30	Various			2005	58,311	6,185	7-15	6,185		49,668	30
31	Various			2006	214,383	14,838	5-25	14,838		98,558	31
32	Various			2007	65,275	5,619	8-25	5,619		27,421	32
33	Various			2008	196,310	17,433	5-25	17,433		70,378	33
34											34
35											35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete

See Page 12A, Line 70 for total

Facility Name & ID Number Resurrection Nursing and Rehab Center # 0044362 Report Period Beginning: 07/01/2011 Ending: 06/30/2012

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$	$	$	37
38	ComEd Smart Ideas Program - Lighting Retrofit	2009	1,090	109	10	109		273	38
39	ComEd Smart Ideas Program - Lighting Retrofit	2009	408	41	10	41		162	39
40	ComEd Smart Ideas Program - Lighting Retrofit	2009	1,244	124	10	124		311	40
41	ComEd Smart Ideas Program - Lighting Retrofit	2009	1,744	174	10	174		436	41
42	ComEd Smart Ideas Program - Lighting Retrofit	2009	14,296	1,430	10	1,430		3,574	42
43	CMS Response 2009	2009	6,028	603	10	603		1,507	43
44	Survey if facilities for electrical equipment	2009	4,000	667	3	667		4,000	44
45	REMOVE OLD EJECTOR PUMP & REPLACE W/ NEW 3" SUBMERSIBLE PU	2009	6,888	459	15	459		1,607	45
46	PROVIDE ELECTRICAL ENGINEERING SERVICES FOR RNRC - FINAL	2009	2,531	253	10	253		886	46
47	L & M TO EXCAVATE & REPAIR WATER MAIN BREAK	2009	5,000	250	20	250		875	47
48	INSTALLATION CHARGE-15 SEC DELAYED EGRESS DOOR HARDWARE F	2009	238	48	5	48		166	48
49	INSTALL NEW EDWARDS FIRE ALARM SYSTEM, REMOVE OLD SYSTEM	2009	85,250	8,525	10	8,525		29,838	49
50	PROVIDE ELECTRICAL ENGINEERING SERVICES FOR RNRC	2009	2,541	254	10	254		889	50
51	PROVIDE ELECTRICAL ENGINEERING SERVICES FOR RNRC	2009	1,250	125	10	125		438	51
52	PROVIDE ELECTRICAL SERVICES FOR RNRC	2009	16,250	1,625	10	1,625		5,688	52
53	REMOVAL & INSTALLATION OF NEW EDWARDS FIRE ALARM SYSTEM	2009	35,010	3,501	10	3,501		12,254	53
54	REMOVAL & INSTALLATION OF NEW EDWARDS FIRE ALARM SYSTEM	2009	32,593	3,259	10	3,259		11,408	54
55	REMOVAL & INSTALLATION OF NEW EDWARDS FIRE ALARM SYSTEM	2009	37,159	3,716	10	3,716		13,006	55
56	RUN ELEVATORS ON INSPECTION FOR ELECTRICIANS	2009	1,586	264	3	264		1,586	56
57	REMOVAL & INSTALLATION OF NEW EDWARDS FIRE ALARM SYSTEM	2009	174,027	17,403	10	17,403		60,909	57
58	FIRE ALARM UPGRADES	2009	6,000	1,000	3	1,000		6,000	58
59	REMOVAL & INSTALLATION OF NEW EDWARDS FIRE ALARM SYSTEM	2009	123,826	12,383	10	12,383		43,339	59
60	REMOVAL & INSTALLATION OF NEW EDWARDS FIRE ALARM SYSTEM	2009	41,460	4,146	10	4,146		14,511	60
61	SURVEY OF FACILITY FOR ELECTRICAL EQUIPMENT	2009	4,031	672	3	672		4,031	61
62	Emergency Power Upgrades	2009	2,016	134	15	134		336	62
63	Lower Level Firestopping	2009	12,803	854	15	854		2,134	63
64									64
65									65
66									66
67									67
68									68
69									69
70	**TOTAL (lines 4 thru 69)**		**$ 14,571,709**	**$ 495,464**		**$ 495,464**	**$**	**$ 13,211,435**	70

****Improvement type must be detailed in order for the cost report to be considered complete**

Facility Name & ID Number Resurrection Nursing and Rehab Center # 0044362 Report Period Beginning: 07/01/2011 Ending: 06/30/2012

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 14,571,709	$ 495,464		$ 495,464	$	$ 13,211,435	1
2	REPLACE BROKEN CONCRETE AT FRONT ENTRANCE	2010	2,700	180	15	180		273	2
3	INSTALLATION OF NEW GAS VALVE REGULATORS ON ALL GAS APPLIAN	2010	11,508	1,151	10	1,151		1,758	3
4	INSTALLATION OF 4 FIRE DAMPERS	2010	15,957	1,596	10	1,596		2,420	4
5	INSTALL 8 NEW SPRINKLERS IN MAIN KITCHEN & BOILER ROOM	2010	2,800	112	25	112		168	5
6	Installation of 4 Tankless Hot Water Units with Return Piping	2010	38,500	3,850	10	3,850		9,625	6
7	Installation of Tankless Hot Water System for Kitchen + Laundry	2010	32,000	3,200	10	3,200		8,000	7
8	L & M TO INSTALL COMPLETE MELINK INTELLI-HOOD SYSTEM	2010	2,284	114	20	114		177	8
9	L&M TO INSTALL COMPLETE MELINK INTELLI-HOOD SYSTEM	2010	6,851	343	20	343		517	9
10									10
11									11
12	DESIGN FEES FOR PHASE 1 RENOVATIONS	2011	16,369	546	15	546		546	12
13	ARCHITECTURAL SERVICES FOR C & D WING RENOVATIONS	2011	29,410	980	15	980		980	13
14	INSTALLATION OF REMOTE ANNUNCIATOR FOR EMERGENCY GENERAT	2011	6,087	254	12	254		254	14
15	FLOOR INSTALLATION IN UNIT # 235 & TEST UNIT	2011	2,395	120	10	120		120	15
16	PROVIDE PLUMBING SERVICE TO INSTALL 14 DUAL CHECK VALVES	2011	3,400	68	25	68		68	16
17	PROVIDE PLUMBING SERVICE TO INSTALL BY-PASS PIPING TO ELIMINA	2011	5,490	110	25	110		110	17
18	PROVIDE PLUMBING SERVICE TO INSTALL NEW PIPING	2011	9,500	190	25	190		190	18
19	REPLACEMENT OF 4 SMOKE DAMPERS	2011	3,559	237	15	237		356	19
20	1ST FLOOR RENOVATION - SPECIALTY SNF - INITIAL DESIGN STUDY	2011	5,000	250	20	250		375	20
21	INSTALL NEW 6 inch VALVE NEW EXHAUST FLU LINES INSTALL 2 WATT	2011	7,892	316	25	316		474	21
22	INSTALL NEW 6 inch VALVE NEW EXHAUST FLU LINES INSTALL 2 WATT	2011	10,866	435	25	435		652	22
23	FIRE SAFETY EQUIVALENCY STANDARD FOR RNRC	2011	2,325	233	10	233		349	23
24		2011							24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	**TOTAL (lines 1 thru 33)**		**$ 14,786,603**	**$ 509,747**		**$ 509,747**	**$**	**$ 13,238,845**	34

****Improvement type must be detailed in order for the cost report to be considered complete**

Facility Name & ID Number Resurrection Nursing and Rehab Center # 0044362 Report Period Beginning: 07/01/2011 Ending: 06/30/2012

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		$ 14,786,603	$ 509,747		$ 509,747	$	$ 13,238,845	1
2	SISTER BONAVENTURE PROJECT	2012	227,929	7,598	15	7,598		7,598	2
3	SISTER BONAVENTURE CONSTRUCTION PROJECT	2012	108,487	2,712	20	2,712		2,712	3
4	DESIGN FEES FOR PHASE 1 RENOVATIONS	2012	10,481	349	15	349		349	4
5	FSES PREPARATION SURVEY	2012	3,960	132	15	132		132	5
6	REVAMPING OF COMBUSTION AIR INTAKE DUCTWORK	2012	2,963	99	15	99		99	6
7	ARCHITECTURAL SERVICES FOR C & D WING RENOVATIONS	2012	7,514	250	15	250		250	7
8	EASYCARE 5 BED LAMINATE PANELS, ASSIST DEVICES	2012	57,420	1,914	15	1,914		1,914	8
9	INSULATION OF DUCTWORK ON ROOF UNIT # 4	2012	7,933	264	15	264		264	9
10	FIRE SAFETY EQUIVALENCY STANDARD FOR RNRC	2012	1,094	55	10	55		55	10
11	FIRE SAFETY EQUIVALENCY STANDARD FOR RNRC	2012	257	13	10	13		13	11
12	L & M TO INSTALL COMPLETE MELINK INTELLI-HOOD SYSTEM	2012	13,703	343	20	343		343	12
13									13
14									14
15	corporate depreciation allocation	2012		281,274		281,274			15
16									16
17	Reconcile dep : Book and Fixed assets regsiter	2012		377		377			17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 15,228,342	$ 805,127		$ 805,127	$	$ 13,252,574	34

****Improvement type must be detailed in order for the cost report to be considered complete**

Facility Name & ID Number Resurrection Nursing and Rehab Center # 0044362 Report Period Beginning: 07/01/2011 Ending: 06/30/2012

XI. OWNERSHIP COSTS (continued)

C. Equipment Costs-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 2,252,435	$ 55,903	$ 55,903	$	8-20	$ 2,050,916	71
72	Current Year Purchases	14,031	702	702		10	702	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	$ 2,266,466	$ 56,605	$ 56,605	$		$ 2,051,618	75

D. Vehicle Costs. (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Residence	1993 Oldsmobile	1993	$ 18,286	$	$	$		$ 18,286	76
77	Residence	1997 Buick Centura	1997	18,343					18,343	77
78	Residence	2007 Ford Starcraft	2007	53,983	5,398	5,398			53,983	78
79										79
80	TOTALS			$ 90,612	$ 5,398	$ 5,398	$		$ 90,612	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount		
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 18,165,713	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 867,130	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 867,130	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 15,394,804	85	

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number Resurrection Nursing and Rehab Center # 0044362 Report Period Beginning: 07/01/2011 Ending: 06/30/2012

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
   If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions				N/A			4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34. N/A
   This amount was calculated by dividing the total amount to be amortized N/A
   by the length of the lease .

9. Option to Buy: ☐ YES ☐ NO Terms: *

10. Effective dates of current rental agreement:
    Beginning
    Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2013	$
13.	/2014	$
14.	/2015	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO
16. Rental Amount for movable equipment: $ 28,931 Description: Refer to PG14A for the details.
    (Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Provider Number: 0044362

FYE: 6/30/2012

Attachment to Schedule XII, Line 16- Equipment Rental Cost

Sub Acct 7020

Equipment /Vendor	Amount
Copiers	14,653
CUTLERY SHARPENING & CUTTING EDGE SERVICI	1,411
Food Service Equipment	11,862
Other - Ecolab	1,005
Total Equipment Lease Exp	28,931

Facility Name & ID Number Resurrection Nursing and Rehab Center # 0044362 Report Period Beginning: 07/01/2011 Ending: 06/30/2012

XIII. EXPENSES RELATING TO CERTIFIED NURSE AIDE (CNA) TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If CNAs are trained in another facility program, attach a schedule listing the facility name, address and cost per CNA trained in that facility.)

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?
   - [ ] YES
   - [X] NO

   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

   The CNAs that were hired were already trained.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER CNA ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER CNA ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training CNAs from other facilities.

$

D. NUMBER OF CNAs TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.
(e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

Facility Name & ID Number Resurrection Nursing and Rehab Center # 0044362 Report Period Beginning: 07/01/2011 Ending: 06/30/2012

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2		3	4		5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service		Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	10a	3027	hrs	$ 113,576	644	$ 41,616	$	3,671	$ 155,192	1
2	Licensed Speech and Language Development Therapist	10a	1144	hrs	35,775				1,144	35,775	2
3	Licensed Recreational Therapist			hrs							3
4	Licensed Physical Therapist	10a	6380	hrs	266,493				6,380	266,493	4
5	Physician Care			visits							5
6	Dental Care			visits							6
7	Work Related Program			hrs							7
8	Habilitation			hrs							8
9	Pharmacy	39(2)		# of prescrpts				1,942,692		1,942,692	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)			hrs							10
11	Academic Education			hrs							11
12	Other (specify): COTA	10a				414	21,946		414	21,946	12
13	Other (specify): PT Assist	10a				31	1,637		31	1,637	13
14	TOTAL				$ 415,844	1,089	$ 65,199	$ 1,942,692	11,640	$ 2,423,735	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as CNAs, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number Resurrection Nursing and Rehab Center # 0044362 Report Period Beginning: 07/01/2011 Ending: 06/30/2012

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 06/30/2012 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 356,126	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 2,690,500)	5,689,134		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): OTHER RECEIVABLE	162,719		9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 6,207,979	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments	44,872,126		12
13	Land	580,293		13
14	Buildings, at Historical Cost	14,723,226		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	2,862,604		16
17	Accumulated Depreciation (book methods)	(15,394,804)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 47,643,445	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 53,851,424	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 326,559	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	697,733		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable			30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	DUE TO RMC	3,052,005		36
37	OTHER ACCRUED EXP	67,439		37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 4,143,736	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 4,143,736	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 49,707,688	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 53,851,424	$	48

***(See instructions.)**

Facility Name & ID Number Resurrection Nursing and Rehab Center # 0044362 Report Period Beginning: 07/01/2011 Ending: 06/30/2012

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 48,507,332	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 48,507,332	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	1,200,356	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 1,200,356	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 49,707,688	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number Resurrection Nursing and Rehab Center # 0044362 Report Period Beginning: 07/01/2011 Ending: 06/30/2012

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	I. Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 33,003,493	1
2	Discounts and Allowances for all Levels	(11,672,389)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 21,331,104	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	22,546	13
14	Non-Patient Meals	6,645	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry	18,450	22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 47,641	23
	D. Non-Operating Revenue		
24	Contributions	12,250	24
25	Interest and Other Investment Income***	2,520,080	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 2,532,330	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	From Page	(26,634)	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ (26,634)	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 23,884,441	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	2,909,322	31
32	Health Care	9,091,234	32
33	General Administration	6,907,529	33
	B. Capital Expense		
34	Ownership	1,123,564	34
	C. Ancillary Expense		
35	Special Cost Centers	1,942,692	35
36	Provider Participation Fee	709,744	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 22,684,085	40
41	**Income before Income Taxes (line 30 minus line 40)****	1,200,356	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 1,200,356	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 8,951,968	44
45	Private Pay - Net Inpatient Revenue	4,814,496	45
46	Medicare - Net Inpatient Revenue	7,564,640	46
47	Other-(specify)		47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 21,331,104	49

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? Yes If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

******Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Resurrection Nursing and Rehab Center
Medicaid Provider Number: 0044362
FYE 6/30/2012
Attchment to Line 28, Schedule XVII - Other Revenue

Description	Amount	Remark
Net Assets Released from restrictions	370	Not an income
Admin - Other Revenue	3,636	Offset on Page 5A
Activity - Other Revenue, Negative Amt	(100)	Added bac k on Page 5A
Investment Fees Exp	(30,540)	A-8 Add On on Page 5A
Total - Other Revenue	(26,634)	

Attachment to Line 25 , Schedule XVII - Interest and Other Investment Income

Interest Income	2,520,080	
Interest Expenses	227,503	Page 6
Interest income offset - limited to interest ex	227,503	

Facility Name & ID Number Resurrection Nursing and Rehab Center # 0044362 Report Period Beginning: 07/01/2011 Ending: 06/30/2012

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	2,028	2,116	$ 96,997	$ 45.84	1
2	Assistant Director of Nursing	2,005	2,124	84,127	39.61	2
3	Registered Nurses	99,621	109,271	3,919,736	35.87	3
4	Licensed Practical Nurses	4,032	4,526	109,187	24.12	4
5	CNAs & Orderlies	164,467	182,671	2,487,412	13.62	5
6	CNA Trainees					6
7	Licensed Therapist	25,379	28,163	985,350	34.99	7
8	Rehab/Therapy Aides	19,063	21,396	362,314	16.93	8
9	Activity Director	1,790	2,061	59,633	28.93	9
10	Activity Assistants	11,320	12,354	137,925	11.16	10
11	Social Service Workers	7,197	8,263	160,713	19.45	11
12	Dietician	3,043	3,456	72,466	20.97	12
13	Food Service Supervisor	3,217	3,675	91,611	24.93	13
14	Head Cook	7,580	8,532	120,461	14.12	14
15	Cook Helpers/Assistants	32,004	35,530	372,411	10.48	15
16	Dishwashers					16
17	Maintenance Workers	7,193	7,942	173,023	21.79	17
18	Housekeepers	26,093	29,828	366,116	12.27	18
19	Laundry	16,691	18,887	201,804	10.68	19
20	Administrator	1,894	2,116	121,061	57.21	20
21	Assistant Administrator					21
22	Other Administrative	19,489	21,941	399,814	18.22	22
23	Office Manager					23
24	Clerical					24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director	118	118	20,571	174.33	27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Ca care cordinator	7,759	8,528	319,295	37.44	32
33	Other(specify) Chaplains	4,283	5,120	121,940	23.82	33
34	TOTAL (lines 1 - 33)	466,266	518,618	$ 10,783,967 *	$ 20.79	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant		$		35
36	Medical Director				36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		$		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses				51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)		$		53

Facility Name & ID Number Resurrection Nursing and Rehab Center # 0044362 Report Period Beginning: 07/01/2011 Ending: 06/30/2012

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Farlee, James R	Administrator		$ 121,061
(Refer to PG 5A for Reclass)			
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 121,061

B. Administrative - Other

Description	Amount
Management Fees	$ 2,013,099
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	$ 2,013,099

C. Professional Services

Vendor/Payee	Type	Amount
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed $5,000, attach copy of invoices.)		$

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 102,188
Unemployment Compensation Insurance	26,634
FICA Taxes	776,283
Employee Health Insurance	1,504,482
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Employee Assistance Program	5,398
Group Dental Insurance	42,876
Group Disability Ins	40,004
Group Life Insurance	18,315
Other Benefts	6,110
Retirement Benefits	550,466
Tuition Reimbursement	35,004
TOTAL (agree to Schedule V, line 22, col.8)	$ 3,107,760

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
TOTAL		$

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	
Health Care Worker Background Check	
(Indicate # of checks performed)	
Patient Background Checks	
ILRTA	195
Life Serv	6,258
Living De	239
Open Arms	185
AllScripts	2,315
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 9,192

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$

**See instructions.

Facility Name & ID Number Resurrection Nursing and Rehab Center # 0044362 Report Period Beginning: 07/01/2011 Ending: 06/30/2012

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014	FY2015
1	N/A	N/A	$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number Resurrection Nursing and Rehab Center # 0044362 Report Period Beginning: 07/01/2011 Ending: 06/30/2012

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **No**

(2) Are there any dues to nursing home associations included on the cost report? **No**
If YES, give association name and amount.

(3) Did the nursing home make political contributions or payments to a political action organization? **No** If YES, have these costs been properly adjusted out of the cost report?

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **No** If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **11.5 Yrs.**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **30,143** Line **10(2)**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease. **N/A**

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ **709,744**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **No** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **No** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **None** Has any meal income been offset against related costs? **Yes** Indicate the amount. $ **6,645**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $
c. What percent of all travel expense relates to transportation of nurses and patients? **0**
d. Have vehicle usage logs been maintained? **Adequate Records have been maintained.**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **N/A**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $

(17) Has an audit been performed by an independent certified public accounting firm? **Yes**
Firm Name: **KPMG LLP**

(18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? **Yes**

(19) If total legal fees are in excess of $5,000, have legal invoices and a summary of services performed been attached to this cost report? **N/A**
Attach invoices and a summary of services for all architect and appraisal fees.